

# Out of Hours

## Health care for refugees:

time to get our act together

In October 2015 I joined Turkish, Dutch, Swiss, and Irish GPs to run workshops about refugee children at Wonca Europe in Istanbul. This is obviously a hot topic and was mentioned by many speakers.

Wonca produced a valuable statement encouraging doctors across the continent to uphold refugee and asylum seeker rights to equitable care 'unconditionally and based on a set of core values' fundamental to the practice of family medicine.<sup>1</sup>

### THE UK CONTEXT

So how can we in the UK respond to the challenges? Delivery of primary care for asylum seekers and new refugees in the UK is fragmented. We have NGOs and foreign-aid agencies in our cities struggling to find NHS care for the most vulnerable. There is undoubtedly goodwill among the GPs I meet, and interest from trainees and First5 doctors in knowing more, but there is little in the way of infrastructure and training. GPs are expected to 'get on with it', but asylum seekers are challenging patients; often they don't trust you and are unable to navigate the system. They can be very distressed, some having experienced trauma beyond your comprehension. Their priorities can be low on Maslow's Hierarchy of Needs:<sup>2</sup> safety, warmth, and legal representation. Freedom from pain, both emotional and/or physical, often tied up in their expression of psychological distress, is a frequent demand.

Most asylum seekers are socially and financially deprived, living in fear, and we know their health deteriorates in the asylum system.<sup>3</sup> It's scary to ask the question 'What happened to you?' Even scarier is when you only have 10 minutes and are perhaps under pressure to use inadequate or inappropriate interpretation. Disclosure can be traumatising for the practitioner and the patient. Who wants to end the consultation feeling worse? So, to 'screen and promptly identify cases of violence and abuse, prevent them and intervene in collaboration with the relevant authorities and community resources'<sup>1</sup> can feel quite daunting.

Our role is to provide health care, not decide asylum claims, but many asylum seekers have complex medico-legal needs that remain unaddressed without our advocacy as their doctors.

For 7 years in Salford we had a PCT-managed surgery for asylum seekers

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where we developed expertise and, just as importantly, looked after each other. We had good-quality language and cultural interpretation as well as excellent links with the voluntary sector. We knew how to write letters that actually made a difference for patients. In 2012 we were closed following a failed tendering process: there were no 'willing providers'. No one ever said we weren't doing a good job, but there was 'no way' to commission it directly in the new structure.

Salford CCG and Greater Manchester West Mental Health Trust now support me to work as a GPwSI in a tier 2, but we all recognise its limitations, especially in overcoming the barriers to access. With an influx of new refugees — people with the same hopes, dreams, and fears as you and I — what are we actually going to do to ensure 'sustainable and uninterrupted provision of comprehensive and integrated health care'?<sup>1</sup> Our response to this is the 'canary in a coalmine' analogy: if we can get this safety net right for our most vulnerable patients, then other disempowered communities will also benefit.

### THE HUB AND SPOKE MODEL

People seeking sanctuary arrive on their knees. If we can give them a hand up we will have a young, fit population, keen and able to contribute to our economy. If we don't, we risk social alienation and a chronic disease burden that can be prevented.

In the North West we propose a hub and spoke model: GPs and nurses with specialist knowledge and skills supported by local practices sharing care. Innovations in IT with remote access to notes and co-production by refugees themselves, many of whom bring professional skills, can make for safe, appropriate, culturally sensible, and patient-centred care.

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Strong primary care is an economically sound investment for this group and at such a hub we could provide workplace training in social medicine for our medical students and new GPs.

There are people in the UK who know what needs to be done. Many of us were already doing it prior to 2012, but we need an infrastructure to support us. John Yaphe, Associate Professor in Community Health at the University of Minho, Portugal, said at Wonca:

*'We need the head, the hands, and the heart to make it happen.'*

I would add that we also need the political will, and that we should move now to turn talk into action.

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### REFERENCES

1. Wonca Europe. Wonca Europe 2015 Istanbul statement: refugees should have access to equitable, affordable and high-quality health care services in all Europe. <http://www.woncaeurope.org/sites/default/files/news/Statement%20WONCA%20Europe%202015%20Istanbul%20-%20Final.pdf> (accessed 4 Feb 2016).
2. Simply Psychology. Maslow's Hierarchy of Needs. <http://www.simplypsychology.org/maslow.html> (accessed 4 Feb 2016).
3. Royal College of Psychiatrists. Improving services for refugees and asylum seekers: position statement. London: RCPsych, 2007.